FORM #9
ASSESSMENT OF NEED
FOR NURSING HOME OR ASSISTED LIVING CARE

10-25-00

THIS SECTION TO BE COMPLETED BY RESPONSIBLE FAMILY MEMBER *or* LEGAL REPRESENTATIVE.

Name of LEOFF-I Member: _____ Social Security #:_____

Responsible family member *or* legal representative:_____ Date of Birth: _____

Telephone #: _____

Family home address: _____

_____

Party responsible for payment:_____ Daily rate:_____

Type of accommodate: (private room, semi-private, other)_____

Type of facility: nursing home ☐; or, assisted living care facility ☐ .

Charges for additional services/equipment: Yes ☐ No ☐ If "Yes", attach itemized statement (**required**).

Long-term care insurance? Yes ☐ No ☐ Medicare? Yes ☐ No ☐

Other medical insurance? Yes ☐ No ☐ Name of carrier: _____

THIS SECTION TO BE COMPLETED BY DIRECTOR OF NURSING.

Director of Nursing:_____ Telephone #: _____

Name of nursing home/assisted living care facility: _____

Address of nursing home/assisted living care facility: _____

_____

Who referred resident to your facility?_____

Admitted directly from hospital stay? Yes ☐ No ☐ Hospital:_____

Diagnosis requiring hospitalization: _____

_____

Date of hospital discharge: _____ Discharge summary (**required**) attached. Yes ☐ No ☐

Date of admittance to facility:_____ Level of care required at admittance:_____

Current level of care required (copy of care plan **required**): _____

Signature: _____ Date: _____
Director of Nursing

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THIS SECTION TO BE COMPLETED BY FACILITY MEDICAL DIRECTOR M.D. *or* RESIDENT'S PRIMARY CARE PHYSICIAN.

(Dictate for typing or print <u>ONLY</u>.)

Name of Resident: _____ SSN:_____

Medical Director M.D. or
Primary Care Physician: _____ Telephone: _____

Address:_____

_____

_____

Diagnosis upon admission to facility:_____

_____

History of illness/condition leading up to placement: _____

_____

_____

Patient's prognosis for recovery:_____

_____

Current level of functioning: _____

Current medications (please attach printed list to include name, dosage, frequency):_____

_____

Other providers involved in patient's care since admission: _____

What treatment services have been prescribed--physical therapy, speech therapy, etc. Attach treatment plans for <u>each</u> service (**required**.)

_____

_____

Signature:_____ Date: _____
Medical Director M.D./ Primary Physician

INSTRUCTIONS FOR COMPLETION OF FORM #9
"Assessment of Need for Nursing Home or Assisted Living Care"

Introduction:

Under Board Rule 9.10-G and H, a LEOFF-I member may submit an application for prior approval of reimbursement of costs for long-term custodial care in a nursing home or residential placement in an assisted care facility.

The procedure for submission of a claim requires completion of Form #9, **"**Assessment of Need for Nursing Home or Assisted Living Care", and Form #6, "Member's Claim for Reimbursement of Medical Expenses". Additional required information must then be attached (see below). Finally, all forms and attachments are submitted to the LEOFF-I employer who will complete the application and forward it to the Disability Board for review.

NOTE: Each claim will be considered on a case-by-case basis by the Disability Board.
No claim can be brought before the Board unless all required forms and information have been completed and included in the application packet. Any claim that is submitted with information missing will be returned to the employer or member for completion.

Filling out Form #9:

Form #9, is a two-sided form with three sections. The first (top) section is to be completed by the LEOFF-I applicant.

> Member's identifying information can be filled out by a responsible family member, legal guardian or other appointed representative.
>
> An itemized statement of costs must be attached to the form. This statement should include the facility daily residence rate, charges for medical supplies, medications, and personal care items, and other service charges for additional care.

INSTRUCTIONS FOR COMPLETION OF FORM #9
"Assessment of Need for Nursing Home or Assisted Living Care"
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The second section is to be completed by the Director of Nursing of the facility. If the member was hospitalized within six months preceding placement in the facility, the hospital discharge summary must be provided by the Director of Nursing and attached to Form #9.

The reverse side of Form #9 is to be filled in, signed and dated by the medical physician in charge of the member's care, be it his primary care physician or the physician attending to the care of all residents in the facility (a M.D. designated as "Medical Director"). A list of current medications and treatment plans for each therapy prescribed must be provided by the physician and attached to Form #9.

The completed Form # 9, with required attachments, is to be submitted to the LEOFF-I employer who, in turn, will add an employer's form and submit the completed application to the Disability Board office.

Any questions about the form, procedures for submitting a claim, or other Board policies can be addressed to the Board Clerk Gail Morris at (206) 263-5068.